´		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155115	A. BUILI	DING	00	07/29/2	
		100110	B. WING			0112912	011
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CARDINA	AL NURSING AND F	REHABILITATION CENTER			LASALLE AVE BEND, IN46617		
					BEND, IN-10017		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
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F0000							
10000							
	This visit was for	r the Investigation of	F00	000	The creation and submission		
	Complaint # IN0	0093796.			this plan of correction does n		
	-				constitute an admission by the provider of any conclusion see		
	Complaint # IN0	0093796-Substantiated,			forth in the statement of		
	Federal/State def	iciencies related to the			deficiency, or of any violation	n of	
	allegations are ci	ted at F-282 and F-323.			regulation.This provider		
					respectfully requests that the 2567 plan of correction be	;	
	Survey dates: Jul	y 28 and 29, 2011			considered the letter of credi	ble	
					allegation.		
	Facility number:	0048					
	Provider number	: 155115					
	AIM number:	100275330					
	Survey team:						
	Toni Krakowski,	RN					
	Census bed type:						
	SNF/NF: 110						
	Total: 110						
	Census payor typ	oe:					
	Medicare: 10						
	Medicaid: 80						
	Other: 20						
	Total: 110						
	Sample: 5						
	These state finding	ngs are cited in					
	accordance with	410 IAC 16.2.					
	Quality review co	ompleted on August 3,					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

FERZ11

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155115 07/29/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1121 E LASALLE AVE CARDINAL NURSING AND REHABILITATION CENTER SOUTH BEND, IN46617 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
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CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE 2011 by Bev Faulkner, RN The services provided or arranged by the F0282 facility must be provided by qualified persons SS=D in accordance with each resident's written plan of care. F0282 F282 Services by Qualified 08/28/2011 Based on observation, interview, and Persons/Per Care Plan It is the record review, the facility failed to follow practice of this provider that the Plan of Care to aid in the prevention services be provided or arranged of falls for 1 of 5 residents reviewed for by the facility by qualified persons falls in a sample of 5. in accordance with each resident' s written plan of care. What corrective action(s) will be Resident: #F accomplished for those residents found to have been Findings include: affected by the deficient practice? Resident F: has had no further falls. This resident's Resident #F's clinical record was fall care plan has been thoroughly reviewed on 7/28/11 at 5:25 P.M., and reviewed and updated to reflect indicated diagnoses of, but not limited to, her current status and needs. How other residents depressive disorder, Alzheimer's disease, having the potential to be and subacute subdural hematoma. It affected by the same deficient further indicated she was admitted to the practice will be identified and facility on 5/20/11. what corrective action(s) will be taken? All residents at risk for falls have the potential to be During initial tour of the facility on affected by this finding and will be 7/28/11 at 10:30 A.M., while identified through a facility audit. accompanied by LPN #4, she identified This audit will include review of all Resident #F as a fall risk who had fall care plans. This audit will be completed by the IDT Team. It sustained an injury as a result of a recent will ensure fall care plans fall. accurately reflect each residents needs and include resident A "Fall Risk Assessment," dated 5/20/11, specific interventions for fall

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIT	LDING	00	COMPLETED
		155115	B. WIN			07/29/2011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF	₹		1	LASALLE AVE	
CARDIN	AL NURSING AND	REHABILITATION CENTER		1	I BEND, IN46617	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
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		nt #F had not sustained a			prevention as identified by th IDT Team. What measures v	• • • • • • • • • • • • • • • • • • •
	_	ast three months, but was			be put into place or what	VIII
	considered a fall				systemic changes will be n	nade
	incontinence, im	paired gait/balance,			to ensure that thie deficien	I
	impaired vision,	non-compliance, and			practice does not recur? A	
	confusion.	-			nursing in-service will be hel	
					August 19, 2011. This in-sei	I
	RN #3 indicated	in an interview on			will include review of the faci	
		A.M., that a bed and			policy titled, "Fall Manageme Program" and the facility poli	I
					titled, "Care Plan Review." 1	
		been placed on 5/22/11,			in-service will also stress the	• • • • • • • • • • • • • • • • • • •
	1 -	t #F sustaining any falls in			importance of following	
	the facility becau	use of her unsteady gait.			established care plan	
					interventions to prevent falls	I
	A Care Plan, dat	ed 6/06/11, indicated,			This in-service will be condu	
	"Problem: Resid	ent is at risk for falls due			by the DNS or designee, and	I
	to: unsteady gait	and resident is only able			include a post-test to determ level of understanding. How	I
	to stabilize with	-			corrective action(s) will be	une
		dent has no safety			monitored to ensure the	
		-			deficient practice will not re	ecur,
		roach:Non-skid			i.e., what quality assurance	I
		and change 2 hrs (hours);			program will be put into pla	I
	` ′	ent makes attempts to			To ensure ongoing complian	
		r; unable to put back on:			with this corrective action, th	e
	ensure shoes are	on securely tied;			DNS or designee will be	f tho
	(6/28/11) fall ma	at; (7/18/11) To observe			responsible for completion o CQI Audit tool titled, "Fall	1 1110
	her-frequent atte	empts @ standing, leaning			Management" weekly x 4 we	eeks
	_	ve res. (resident) from			and monthly thereafter. The	
	dining room afte	, ,			Audit tools titled, "Care Plan	
					Review" and "Care Plan	
	A Nursala Nata	dated 7/18/11 at 0:25			Updating" will also be complete	I
	A Nurse's Note, dated 7/18/11 at 9:25				weekly x 4 weeks, monthly a months, and quarterly therea	
	A.M., indicated, "Resident found on				Findings will be reported to t	I
	dining room floor lying on R side. Alarm				CQI Committee for review ar	
	soundingN.O. (new order) received				corrective action if needed	
	from Dr. (Name)) to send Resident to ER			monthly x 4 months, and cor	ntinue
	for Eval. (evalua	ation)"			monthly if corrective action is	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPLETED
		155115	B. WIN			07/29/2011
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>
NAME OF F	PROVIDER OR SUPPLIEF	8			LASALLE AVE	
CARDIN	AL NURSING AND	REHABILITATION CENTER	SOUTH BEND, IN46617			
						1 (715)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
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1110	REGUEZITORI OR	LEGE IDENTIFICATION ORIGINATION	+	1710	required. By what date the	BINE
	D. iC. OT	C D			systemic changes will be	
		Scan Report, dated			completed? Compliance Da	ıte:
	· ·	ed, Reason for exam: ER			8/28/11.	
		On today's exam, there				
	is now a left extr	ra-axial hematoma that				
	measures approx	ximately 8 mm				
	(millimeters)"					
	The "Fall Circun	nstance Report," dated				
	7/18/11 at 9:10 A	A.M., indicated,				
	"Resident in di	ining room up in w/c				
		ablelying on R sideno				
		n @ time of fallinjuries:				
		ead near hairline 3 by 3				
		purple raised area, R				
	` '	cm skin tearResident				
	_	Alzheimer's Dementia with				
	_					
		rbanceintervention (s)				
		n-skid footwear, chair and				
		and change q [every] 2				
	•	rsional activities, remove				
	_	n after meals" The				
		7/19/11, indicated, "we				
	will offer diversi	ional activities. Will				
	continue to obse	rve and F/U as needed"				
	The Director of	Nursing indicated in an				
	interview on 7/2	9/11 at 1:30 P.M.,that				
	Resident #F had	known behaviors prior to				
		cility. "She has poor				
	safety awareness. Her attention span is					
		ong. She propels herself				
	into the dining ro					
		JOIII.				
			1			ı

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155115	B. WING		07/29/2011
NAME OF I	PROVIDER OR SUPPLIER		STREET.	ADDRESS, CITY, STATE, ZIP CODE	•
				LASALLE AVE	
CARDIN	AL NURSING AND I	REHABILITATION CENTER	SOUTH	H BEND, IN46617	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
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TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		on of Resident #F on			
		P.M., she was observed in			
		leaning forward in her			
		her elbows barely resting			
		She was sound asleep			
	1	ond to her name. Her			
		unlocked. She was not			
		d socks; she was wearing			
	1 ~	ton socks and no shoes.			
		ner residents were			
	unsupervised in	the dining room.			
	A C1114111.	€41. 1 UE-11 M			
	1	titled "Fall Management			
	1	d March, 2010, indicated,			
		policy of American			
		ities to ensure residents			
	1 -	he facility will maintain			
		cal functioning through			
	the establishmen				
	environmental, a				
		vent injury related to			
	fallsFall Risk				
		Equipment interventions:			
		loor matspersonal alarm			
		al alarm on bedproper			
		pper socksStaff			
		Anticipate care needs for			
		tsLay down for naps			
		Do not leave unattended			
		bathrooms if fall risk.			
	1 ^ * *	programs for those with			
	behaviors"				
	This Federal tag	relates to complaint			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155115	B. WING			07/29/20	011
			D. (12.1)		DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			1121 E I	LASALLE AVE		
		REHABILITATION CENTER			BEND, IN46617		
(X4) ID		TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION SHOULD DESCRIBE ACTION SHOULD DESCR			(X5)	
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TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENC1)		DATE
	IN00093796.						
	3.1-35(a)(2)						
F0323 SS=G	environment rema hazards as is poss receives adequate devices to prevent Based on observa record review, th evaluate and anal related to falls an interventions to p resulted in a frace #D) and a subdur #F). This deficient residents reviewe 5. Findings include	ation, interview, and e facility failed to lyze causative factors ad develop appropriate brevent a fall which tured femur (Resident ral hematoma (Resident int practice affected 2 of 5 ed for falls in a sample of	F0.	323	F323 – Accidents and Supervision It is the practice this provider to ensure that the resident environment remains free of accident hazards as is possible; and that each reside receives adequate supervision and assistance devices to preaccidents. What corrective action(s) will be accomplish for those residents found to have been affected by the deficient practice? Resident Has been discharged from fa Resident F: Has experience further falls. Fall care plan has been thoroughly reviewed an	ne s s s lent on event hed o t D: acility. d no as	08/28/2011

NAME OF PROVIDER OR SUPPLIER NAME OF PROVIDER OR SUPPLIER CARDINAL NURSING AND REHABILITATION CENTER NAME OF PROVIDER OR SUPPLIER CARDINAL NURSING AND REHABILITATION CENTER NAME OF PROVIDER OR SUPPLIER CARDINAL NURSING AND REHABILITATION CENTER NAME OF PROVIDER OR SUPPLIER SUPPLIER OF THE PROPERTY OF THE PROPE	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
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A "Fall Risk Assessment," dated 5/20/11, indicated Resident #F had not sustained a fall within the past three months, but was considered a fall risk because of incontinence, impaired gait/balance, impaired			155115	- 1			07/29/20	011
TAGE OF PROVIDER OS SUPPLIER CARDINAL NURSING AND REHABILITATION CENTER SUMMAY STATEMENT OF DEFICIENCES (FACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION DATE PREFIX TAG SUMMAY STATEMENT OF DEFICIENCES (FACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION DATE PREFIX TAG TOWNERS TRANSPORTER CORRECTIONS (OS) COMPLETION DATE TAG TOWNERS TRANSPORTER CORRECTIONS (OS) PROVIDED TRANSPORTER CORRECTION TO COMPLETION DATE TAG TOWNERS TRANSPORTER CORRECTION TO COMPLETION DATE TAG TOWNERS TRANSPORTER CORRECTION TO COMPLETION DATE TAG TOWNERS TRANSPORTER CORRECTION TO COMPLETION TO COMPLETE TRANSPORTER CORRECTION TO C				B. WIN		ADDRESS OFFI STATE ZIR CODE		
CARDINAL NURSING AND REHABILITATION CENTER SOUTH BEND, IN46617	NAME OF F	PROVIDER OR SUPPLIEF	8		1			
SUMMARY STATEMENT OF DEFICIENCIES PREFIX GEACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OF ILSE (DENTIFYING INFORMATION) Teviewed on 7/28/11 at 5:25 P.M., and indicated diagnoses of, but not limited to, depressive disorder, Alzheimer's disease, and subacute subdural hematoma. It further indicated she was admitted to the facility on 5/20/11. During initial tour of the facility on 7/28/11 at 10:30 A.M., while accompanied by LPN #4, she identified accompanied by LPN #4, she identified Resident #F as a fall risk who had sustained an injury as a result of a recent fall. A "Fall Risk Assessment," dated 5/20/11, indicated Resident #F had not sustained a fall within the past three months, but was considered a fall risk because of incontinence, impaired gait/balance, impaired vision, non-compliance, and confusion. A Nurse's Note, dated 6/6/11 at 12:30 P.M., indicated, "Resident was observed to be lying on the floor, she was assisted to her w/c (wheel chair) by this unit and CNA. For intervention resident is to be checked every two hours and taken to the bathroom" Diameter Tag PROVIDERS HLANDICORRIST (COMPLETION OF ACT ALL ANDICORDITION OF ACT ALL					1			
REFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) reviewed on 7/28/11 at 5:25 P.M., and indicated diagnoses of, but not limited to, depressive disorder, Alzheimer's disease, and subacute subdural hematoma. It further indicated she was admitted to the facility on 5/20/11. During initial tour of the facility on 7/28/11 at 10:30 A.M., while accompanied by LPN #4, she identified Resident #F as a fall risk who had sustained an injury as a result of a recent fall. A "Fall Risk Assessment," dated 5/20/11, indicated Resident #F had not sustained a fall within the past three months, but was considered a fall risk because of incontinence, impaired vision, non-compliance, and confusion. A Nurse's Note, dated 6/6/11 at 12:30 P.M., indicated, "Resident was observed to be lying on the floor, she was assisted to her w/c (wheel chair) by this unit and CNA. For intervention resident is to be checked every two hours and taken to the bathroom" PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG Updated to reflect accurate and appropriate interventions to prevent falls. How other residents having the potential to be affected by the same deficient practice will be identified as being at risk for falls what corrective action, will be taken? All residents having the potential to be affected by the same deficient practice will be identified as being at risk for falls will will include completion of a new Fall Assessment for each resident. Any resident learned and updated to accurately reflect resident specific interventions including use of almost and updated to accurately reflect resident specific interventions including use of almost and updated to accurately reflect resident specific interventions including use of almost and updated to accurately reflect resident specific interventions including use of almost and updated to accurately reflect resident specific interventions including use of almost and updated to accurately reflect resident specific interventions including use of almost and updated to accurately	CARDINA	AL NURSING AND	REHABILITATION CENTER		SOUTH	I BEND, IN46617		
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A "Fall Circumstance Report," dated This in-service will be conducted by the DNS and/or designed and		A "Fall Circumstance Report," dated						
by the DNS and/or designee and will include review of the facility		6/6/11 at 12:30 P.M., indicated the fall						
had taken place in the resident's room. had taken place in the resident's room. policy titled, "Fall Management								
She had been sitting on her bed prior to Program". This in-service will		_						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155115	B. WIN			07/29/2	011
		l .	B. WII.		ADDRESS, CITY, STATE, ZIP CODE	l .	
NAME OF	PROVIDER OR SUPPLIEF	8		1	LASALLE AVE		
CARDIN	AL NURSING AND	REHABILITATION CENTER		1	I BEND, IN46617		
					. 52.15,		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· `	ICY MUST BE PERCEDED BY FULL		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION DATE
IAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			IAG	also include review of fall		DATE
		fully clothed with			prevention practices and follo	owing	
		on. It further indicated the			established care plan	Jwing	
	call light was in	reach and the alarm was			interventions, and a post-tes	t to	
	sounding.				determine level of understan		
					Fall Risk Assessments are		
	Nurse's Notes, d	ated 6/11/11, indicated,			completed on admission,		
		esident alert and oriented			annually, quarterly and with		
		fusion noted @ all times.			significant change in condition The DNS or Designee will be		
	1	& B [bowel and bladder].			notified at time of fall to deter		
		-			appropriate and immediate		
		unsteady gait. Mobile via			interventions. All falls will		
		No safety awareness.			continue to be reviewed in th	e	
		nd w/c to alert staff when			daily IDT meetings. Care pla		
	_	11:05 A.M.: "fell in			will be updated daily based of		
	dining area from	w/c. Resident attempting			assessment, physician order	S,	
	to remove shoe.	Was leaning forward and			and IDT review. Causative factors will be determined an	d fall	
	fell out of w/c. S	shoe was underneath w/c.			care plans will be reviewed a		
	Resident landed	on left side. Head hit			updated. Any changes, new		
		a above left eye on			interventions or updates to the	ne	
		e Nurse's Note indicated			care plan and Resident Care		
		amily had been notified of			Sheet will be communicated		
					caregivers at that time. How	the	
		ly elected not to have			corrective action(s) will be monitored to ensure the		
	resident sent to t	he ER (emergency room).			deficient practice will not re	ecur	
					i.e., what quality assurance	-	
	,	sciplinary Team) Progress			program will be put into pla		
	Note, dated 6/13	/11, indicated, "IDT			To ensure ongoing complian		
	review of fall 6/	11/11 at 11:05 A.M.			with this corrective action, the		
	Gripper socks	were immediate			DNS and/or designee will be		
		Γ decided staff to ensure			responsible for completion of	tne	
					CQI Audit tool titled, "Fall Management" weekly x 4 we	eks	
	shoes on appropriately and continue to observe and F/U (follow up) as needed."				and monthly thereafter. In	CAG	
	observe and F/O (follow up) as needed."				addition, compliance with the	use	
	A Nurse's Note, dated 6/27/11 at 10:00				of resident specific assistive		
	· ·				devices will be monitored thr	•	
		"put to bed to sleep and			routine rounds and observati		
	after a while she	was found on the floor			Any identified findings or trer	nds	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155115			ULTIPLE CO LDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/29/2011	
		155115	B. WIN			0772972011
NAME OF P	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE	
CADDINI	AL NILIDOINIC AND I	REHABILITATION CENTER		1	LASALLE AVE I BEND, IN46617	
					I BEND, IN40017	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
1110		Bed alarm in place, call	+	1110	will be reported to the CQI	DATE
		e had a bump on her R			Committee monthlyfor review	v and
	(right) forehead	•			corrective action if indicated	By
	` • ′	eport," dated 6/27/11 at			what date the systemic changes will be completed	,
		ated Resident #F had			Compliance Date: 8/28/11.	<i>'</i>
	=	put to bed and was later				
		or in her night gown. It				
		the floor was dry,				
		nd the room light was				
		ediate intervention put in				
		e floor mat at the side of				
	-	n-skid socks on while in				
	` ′	the Nurse's Note or the				
		ee Report indicated the				
		ounding; however, an IDT				
		11, indicated, "Pt.				
	(patient) alarm w					
	(patrone) anarm w	us sounding.				
	Review of a CT ((CAT) Scan Report, dated				
		d, "Reason for exam:				
		story: Head Injury.				
		nfusionNo subarachnoid				
		nial hemorrhage is				
	evident"	5				
	A Nurse's Note.	dated 7/18/11 at 9:25				
	· · · · · · · · · · · · · · · · · · ·	"Resident found on				
	· · · · · · · · · · · · · · · · · · ·	r lying on R side. Alarm				
	_	[new order] received				
		to send Resident to ER				
	for Eval. [evalua					
		_				
	Review of a CT S	Scan Report, dated				
		d, Reason for exam: ER				
	,	*				<u> </u>

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

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000048

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE S COMPL		
		155115	A. BUILDING B. WING			07/29/2	
NAME OF I	PROVIDER OR SUPPLIER		l l		DDRESS, CITY, STATE, ZIP CODE	!	
CARDIN	AL NURSING AND I	REHABILITATION CENTER	I .		LASALLE AVE BEND, IN46617		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· `	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF.	- 1	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	COMPLETION DATE
		On today's exam, there					
	is now a left extr measures approx	a-axial hematoma that					
	[millimeters]"	imatery 8 mm					
	TI UE 11 C'	D (11.1					
	7/18/11 at 9:10 A	nstance Report," dated					
		ning room up in w/c at					
		R sideno shoes or socks					
		Iinjuries: Middle of					
	forehead near ha	•					
	1	ble raised area, R elbow 1 tearResident diagnosis					
	with Alzheimer's	_					
		banceintervention (s)					
		n-skid footwear, chair and					
	1 ^	and change q (every) 2					
	hours, offer diver	rsional activities, remove					
	from dining roon	n after meals" The					
	•	7/19/11, indicated, "we					
		onal activities. Will					
	continue to obsei	rve and F/U as needed"					
	RN #3 indicated	in an interview on					
		A.M., that a bed and					
		peen placed on 5/22/11,					
	l ^	#F sustaining any falls in					
	the facility.						
	Resident #F's Ad	mission Minimum Data					
	` ′	ssment, dated 5/31/11,					
		l poor decision-making					
	1 ^	ed cues and supervision.					
	It further indicate	ed she needed extensive					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155115	B. WIN	G		07/29/2011	
NAME OF I	PROVIDER OR SUPPLIER	= L			ADDRESS, CITY, STATE, ZIP CODE	-	
O A D D I N	AL AUTOONIO AND I	DELLA DIL ITATIONI GENITED		1	LASALLE AVE		
CARDINA	AL NURSING AND I	REHABILITATION CENTER		SOUTH	I BEND, IN46617		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E	IPLETION DATE
IAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DIA (CILACT)		DATE
	physical assistance of two persons for						
	transferring.						
	A Como Diam date	ad 6/06/11 indicated					
	· ·	ed 6/06/11, indicated, ent is at risk for falls due					
	to stabilize with	and resident is only able					
		dent has no safety					
		roach:Non-skid					
		and change 2 hrs [hours];					
		nt makes attempts to					
		r; unable to put back on:					
	ensure shoes are	•					
		t; (7/18/11) To observe					
	l ` ′	mpts @ standing, leaning					
	1 ^						
		ve res.[resident] from					
	dining room after	r meais					
	The Director of N	Nursing indicated in an					
		9/11 at 1:30 P.M., that					
		known behaviors prior to					
		cility. "She has poor					
		Her attention span is					
	1	ong. She propels herself					
	into the dining ro	C 1 1					
	into the diffing to	ZIII.					
	During an intervi	iew with Occupational					
	_	_					
	Therapist #4 on 7/29/11 at 1:45 P.M., she indicated Resident #F gets tired and then						
	leans in the chair. "When she's awake she						
	sits nice and straight, if she gets fatigued						
	she leans forward. Planned naps would						
	probably benefit	-					
	producty benefit						
	L						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155115		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE : COMPL 07/29/2	ETED	
NAME OF I	PROVIDER OR SUPPLIEI	 			ADDRESS, CITY, STATE, ZIP CODE	!	
				1	LASALLE AVE		
		REHABILITATION CENTER			BEND, IN46617		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	Social Service S	taff #5 indicated in an					
	interview on 7/2	9/11 at 2:00 P.M.,					
		ends activities like music					
	and bingo. Pretty	y much anything that					
	involves eating of	or music."					
	_	ion of Resident #F on					
		P.M., she was observed in					
		leaning forward in her					
		her elbows barely resting					
		She was sound asleep ond to her name. Her					
	1 *	unlocked. She was not					
		d socks; she was wearing					
		tton socks and no shoes.					
	1 -	her residents were					
	unsupervised in						
		C					
	2. Resident #D's	clinical record was					
	reviewed on 7/2	8/11 at 4:45 P.M., and					
	indicated diagno	ses of, but not limited to,					
	· ·	p fracture, muscle					
	weakness, and a	dvanced dementia.					
	A UE-11 Circ	tanaa Danaut II data d					
	1	tance Report," dated I Resident #D sustained					
	an unwitnessed	i Nesiuciii #D sustailicu					
		2:00 P.M., and was found					
		m beside w/c (wheel					
	1	o beddid not use call					
	1 '	got himself up out of w/c					
	and lost his balance and landed on his						
	bottomWhat in	ntervention (s) was put in					
	to place to preve	ent another fall? Already					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	155115	A. BUI	LDING	00	07/29/2	
		100110	B. WIN		A DDDEGG CITY CTATE ZID CODE	0172372	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE LASALLE AVE		
CARDIN	AL NURSING AND F	REHABILITATION CENTER		1	I BEND, IN46617		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	· ·	ms, toilet program after					
	meals. Enc. (enco	O /					
		of room, join other res.					
	(residents) to talk	t or watch 1 v.					
	Review of April,	May, June, and July					
	incident reports i	ndicated Resident #D					
	also sustained a f	Fall on 4/28/11, 6/09/11,					
	6/25/11, and 7/16	5/11.					
	D 11 . //D! #D	1170:1					
		all Risk Assessments,"					
		d 8/4/10, indicated he					
	1	falls during the previous					
		each assessment. The					
		risk Assessment," dated					
	• •	ated the same. All three					
		cated Resident #D was					
	non-compliant.						
	An Interdisciplin	ary Team Progress Note					
	(IDT), dated 6/9/	11, indicated, "Fall					
	6/9/11 at 3:30 A.	M. Found on floor in his					
	room. Was in bed	d sleeping found lying on					
	his left side in nig	ght clothes. Laceration to					
		nd top of right eyebrow.					
		rention 15 minute checks					
	and bed alarm in	itiated"					
	 Resident #D's Ca	re Plan, initiated					
		ed, "Problem: Res					
	· ·	sk for falls d/t (due to)					
	l ` ′	awareness, hx (history)					
	1 * * * *	use call liteApproach:					
		r with assist offer to					

ION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155115	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE :	
			A. BUII		00	07/29/2	
		100110	B. WIN		A DDDEGG OWN CHARE ZID CODE	0172372	011
NAME OF PROVIDER OR SUPPLIER				ı	ADDRESS, CITY, STATE, ZIP CODE LASALLE AVE		
CARDINAL NURSING AND REHABILITATION CENTER				I	BEND, IN46617		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG				TAG	DEFICIENCY)		DATE
	motion] unchanged after fall. Resident						
		complaints of] pain at this					
		t 4:16 P.M.: "Resident					
	1 -	down in bed. Nurse help					
		bed. Placed call light					
		ed resident to use call					
		button showed resident					
		6/11 at 5:40 P.M.:					
		iding off resident trying					
	1 ~	Nurse and CNA assisted					
	1	wheel chair] for dinner.					
	_	ne." 7/16/11 at 5:45 P.M.;					
		as in dining room he c/o					
		order to send to ER					
	1	n] for eval [evaluation]					
	treatment." A "F						
		16/11 at 4:00 P.M.,					
	· ·	ent was in bed prior to					
		ling when res. found on					
		as toileted within one					
	_	hipsters onResident					
	1	how fall occurred					
		note, dated 7/18/11,					
	l '	eview of fall on 7/16/11					
		denied pain at time of					
		s placed at bedside. Will					
		ional activities. Res. c/o					
		5 P.M. and was sent to					
		mitted to hospital with R					
	hip fracture"						
		y and Physical, dated					
		d, "Elderly male presents					
	with hip fracture	and abnormal x-rays that					

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Event ID:

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If continuation sheet

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155115	A. BUII	(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING 00 COMPI B. WING 07/29/2		ETED	
NAME OF PROVIDER OR SUPPLIER CARDINAL NURSING AND REHABILITATION CENTER				STREET A	ADDRESS, CITY, STATE, ZIP CODE LASALLE AVE I BEND, IN46617		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ГЕ	(X5) COMPLETION DATE
	cancerHe had a point. The patier point to go with At one point he point, however, plans for further other than trying fracture" During interview at 5:15 P.M., she was very non-cocall light. "He di he had to use the He would just go himself." Review of Resid Minimum Data Stated 5/01/11, in severely impaired 15. It also indicassistance of one assistance. A facility policy Program," revise "Policy: It is the Senior Community residing within the serior of the serior community						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		155115	A. BUILDING	00	07/29/2011	
			B. WINGSTREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER		l l	LASALLE AVE		
		REHABILITATION CENTER	SOUTH	H BEND, IN46617		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B		
TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE		
		vent injury related to			DATE	
	fallsFall Risk	vent injury related to				
		Equipment interventions:				
		loor matspersonal alarm				
	on chair, persona	al alarm on bedproper				
		oper socksStaff				
		Anticipate care needs for				
		tsLay down for naps				
		Do not leave unattended				
		bathrooms if fall risk.				
		programs for those with				
	behaviors"					
	This Federal tag	relates to complaint				
	IN00093796.	relates to complaint				
	11100073770.					
	3.1-45(a)(2)					